PAYMENT FOR MEDICAL CARE AND SERVICES

1. Inpatient hospital services: See Attachment 4.19-A.

2. a. Outpatient hospital services: as indicated for specific services listed elsewhere in this attachment, e.g., physicians' services, prescribed drugs, therapy services.

   b. (This paragraph intentionally left blank.)

   c. Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC): RHC and FQHC reimbursement will adhere to Sections 1902(a)(13)(C) and 1903(m)(2)(A) of the Social Security Act as amended by Section 4712 of the Balanced Budget Act of 1997. RHC and FQHC core services will be reimbursed reasonable cost defined as the lesser of the Medicare core services payment limit or audited costs pursuant to 42 CFR 405.2400 through 405.2472. Interim payments in any year will be based on the most current Medicare core services payment limit for all core services except mental health services, EPSDT examinations, antepartum care, and global maternity with vaginal or caesarean delivery, which will receive interim payment based on Medicaid's published fee schedule for physicians. Any retroactive amounts due Medicaid or owing the provider as a result of a Medicare or Medicaid audit will be collected or paid over the three month period following issuance of the audit. Non-core services, such as dental services, will also be paid according to Medicaid's published fee schedule and retroactively reimbursed reasonable cost. For Medicaid recipients enrolled in a managed care plan, supplemental quarterly payments are made for any service rendered by the RHC/FQHC as a managed care plan provider. The supplemental payment is the difference between the managed care plan payment and the current Medicare core services payment limit. Reasonable cost reimbursement is subject to the following: 95% of reasonable cost for services furnished during fiscal year (FY) 2000, 90% for FY 2001, 85% for FY 2002, and 70% for FY 2003 and thereafter.

FQHC

3. Laboratory and x-ray services: lower of a) billed charge, or b) fixed fee per unit value of the 1974 California Relative Value Studies (CRVS) as modified by implementation of Current Procedural Terminology.

4. a. Skilled nursing facility services for age 21 and over: see Attachment 4.19-D.

   b. Early and periodic screening: lower of a) billed charge, or b) fixed fee per unit value of the 1974 CRVS as modified; diagnosis and treatment: as indicated for specific services listed elsewhere in this attachment.

   c. Family planning services and supplies: as indicated for specific services listed elsewhere in this attachment, e.g., physicians' services, prescribed drugs.

5. Physicians' services: (1) purchased laboratory services: lowest of a) maximum authorized by Medicare, b) billed charge, c) laboratory charges to physician, or d) fixed fee per unit value of the 1974 CRVS as modified by implementation of Current Procedural Terminology; (2) all others: lower of a) billed charge, or b) fixed fee per unit value of the 1974 CRVS as modified by implementation of Current Procedural Terminology.

6. Medical care and any other type of remedial care provided by licensed practitioners:

   a. Podiatrists' services: ~~lower~~ lowest of a) billed charge, ~~or~~ b) fixed fee per unit value of the 1974 CRVS as modified, OR c) maximum allowed by Medicare.

   b. Optometrists' services: ~~lower~~ lowest of a) billed charge, ~~or~~ b) fixed fee per unit value of the Nevada Relative Value Scale for Ocular Services as modified by implementation of Current Procedural Terminology. See also 12.d, or c) maximum allowed by Medicare

   c. Chiropractors' services: ~~lower~~ lowest of a) billed charge, ~~or~~ b) fixed fee per unit value of the 1974 CRVS as modified by Current Procedural Terminology implementation, OR c) maximum allowed by Medicare.

d. Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife: lower of a) billed charge, or b) fixed fee per unit value of the 1974 CRVS or 1989 Relative Value for Physicians (RVP) as modified by Current Procedural Terminology.

e. Psychologists: lower of a) billed charges, or b) fixed fee per unit value of 1974 CRVS or RVP.

7. Home health care services:

a. Intermittent or part-time nursing services provided by a home health agency: lower of a) billed charge, or b) fixed fee schedule.

b. Intermittent or part-time nursing services when no HHA: lower of a) billed charge, or b) fixed fee per hour.

c. Home health aide services provided by a home health agency: lower of a) billed charge, or b) fixed fee schedule.

d. Equipment and appliances: retail charge less negotiated discount.

e. Physical, occupational or speech therapy provided by a home health agency: lower of a) billed charge, or b) fixed fee schedule.

f. Disposable supplies:

1) If a supply item has a National Drug Code (NDC) number and is listed: lower of a) billed charge, or b) 90% of Average Wholesale Price (AWP) as indicated on the current listing provided by the First Data Bank plus a handling fee.

2) If a supply does not have an NDC number, is not listed and Medicaid has established a published fixed fee: lower of a) billed charge, or b) fixed fee schedule.

3) If a supply does not have an NDC number, is not listed and Medicaid has not established a published fixed fee: 70% of billed charge.

4) Payments for disposable supplies for Medicare crossover clients will not exceed the upper limits at 42 CFR 447.304.

8. Private duty nursing services: audited billed charges.

9. Clinic services: as indicated for specific services listed elsewhere in this attachment, e.g., physicians' services, prescribed drugs, therapy.

10. Dental services: lower of a) billed charge, or b) fixed fee per unit value.

11. a. Physical therapy: lower of a) billed charge, or b) fixed fee per unit value of the Nevada Relative Value Scale for Therapy (NRVS-T) or RVP.

    b. Occupational therapy: lower of a) billed charge, or b) fixed fee per unit value of the NRVS-T or RVP.

    c. Services for individuals with speech, hearing, and language disorders: lower of a) billed charge, or b) fixed fee per unit value of the NRVS-T or RVP.

    d. Respiratory therapy; lower of a) billed charge, or b) fixed fee per unit value of the 1974 CRVS or RVP.

12. a. Nevada Medicaid will meet all reporting and provision of information requirements of section 1927(b)(2) and the requirements of subsections (d) and (g) of section 1927.

The State assures that the State will not provide reimbursement for an innovator multiple source drug, subject to the Federal Upper Limits (42 CFR 447.332(a)), if, under applicable State law, a less expensive non-innovator multiple source drug could have been dispensed.

1. Payment for multiple source drugs shall be the lowest of (a) Specific Upper Limit (SUL) as established by the Health Care Financing Administration (HCFA) for listed multi-source drugs plus a professional fee; (b) Estimated Acquisition Cost (EAC) plus a professional fee; (c) the pharmacist's usual and customary charge; or (d) billed charge.

2. Payment for covered drugs other than multiple source drugs subject to the Federal Upper Limits shall not exceed the lower of (a) EAC plus a professional fee; (b) the pharmacist's usual and customary charge to the general public; or (c) providers actual charge to Medicaid agency.

3. Estimated Acquisition Cost (EAC) is defined by Nevada Medicaid as Average Wholesale Price (AWP) as indicated on the current listing provided by the First Data Bank, minus ten (10) percent.

4. The SUL for multi-source drugs for which an upper limit has been set does not apply if a physician certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient, and the statement "brand medically necessary" appears on the face of the prescription.

6. The State's dispensing fees are defined as (a) those given to outpatient pharmacists at a rate of $4.64 per prescription; (b) those given Home Health Care providers for home intravenous therapy at $16.80 per dose for the first medication and $5.60 per dose for a second medication given concurrently; (c) those given to pharmacists for intravenous therapy in the nursing facility at $11.20 per dose for the first medication and $5.60 per dose for a second medication given concurrently.

There is no co-payment requirement on medications of beneficiaries.

12. b. Dentures: lower of a) billed charge, or b) fixed fee per unit value. See also 10.

c. Prosthetic devices: (1) hearing aids: wholesale cost plus fixed fee; (2) all others: retail charge less negotiated discount.

d. Eyeglasses: (1) frames: wholesale cost to a fixed maximum; (2) lenses: laboratory invoice cost; (3) material services: lower of a) billed charge, or b) fixed fee per Medicaid assigned unit value.

13. a. Other diagnostic services: lower of a) billed charges, or b) fixed fee per unit value.

b. Other screening services: lower of a) billed charges, or b) fixed fee per unit value.

c. Other preventive services: lower of a) billed charges, or b) fixed fee per unit value.

d. Other rehabilitative services: PROVIDED WITH LIMITATIONS:

(1) The payment rate is consistent with efficiency, economy and quality of care and is sufficient to enlist enough providers. Payment will not exceed the prevailing charges in the locality for comparable services under comparable circumstance. The upper limits for reimbursement will not exceed the amounts paid under Medicare for similar services in intermediate care facilities, less an amount identified as that part of the cost apportioned to items, services and equipment required for a twenty-four hour a day facility.

The payment rate is lower of either billed charges or a fixed maximum rate. There is an hourly and a daily maximum rate. The daily rate is used for care of six hours or more per day.

14. a. Services for 65 or older in institutions for TB: NOT PROVIDED.

b. Services for 65 or older in IMD: see Attachment 4.19-A and 4.19-D.

15. Intermediate care facility services: see Attachment 4.19-D.

a. ICF/MR services: see Attachment 4.19-D.

16. Inpatient psychiatric facility services under 21: see Attachment 4.19-A.V.

17. Nurse-midwife services: Paid as with Nurse Practitioners under Attachment 4.19-B, paragraph 6.d.

18. Transportation: (1) ambulance: lower of: a) billed charge, or b) fixed basic rate in town plus fixed fee per mile out-of-town; (2) public carrier: voucher cost; (3) private automobile: fixed fee per mile.

19. Case management for the mentally ill, mentally retarded, and the developmentally delayed infants and toddlers will be paid at the lower of: a) billed charges, or b) a prospectively determined hourly rate. Payment will be made using quarter hour increments for the actual time spent providing case management services. Case management for child protective services and juvenile probation is paid as a monthly encounter rate based on costs.

20. a. Services of Christian Science nurses: NOT PROVIDED.

b. Services in Christian Science sanitoria: NOT PROVIDED.

c. Hospice Services: provided only for Healthy Kids (EPSDT) recipients. Lower of billed charge or Medicare rate.

21. Skilled nursing facility services under 21: see Attachment 4.19-D.

22. Emergency hospital services out-of-state: lower of: a) billed charges, or b) local Medicaid maximums.

23. Personal care services in recipients' home: contracted hourly wage.

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24. Primary Care Case Management (PCCM):

Rates are set based upon the costs incurred by similar client populations in the Medicaid Fee-For-Service (FFS) program. These rates will not exceed the cost of providing the same services on a fee-for-service basis to an actuarily equivalent non-enrolled population group.

Separate rates are established by geographical area (Clark County and Washoe County plus surrounding areas) and also by the following age groupings: under 1, 1-17, 18-64, 65+ (in an institutional setting), and 65+ (not in an institutional setting).

Effective February 1, 1993, PCCM rates for recipients under age 65 are adjusted in the following manner (no adjustment is made for the Aged categories):

a. Costs are aggregated for all ADC, CHAP, and Child Welfare recipients by age (under 1, 1-17, 18-64) and provider type. The costs are also divided according to the recipients' residence (Clark County and Washoe County plus surrounding areas).

- All maternity patients and babies who were in a neonatal intensive care unit are excluded from the rate development. The maternity patients are excluded because of the dramatically higher costs for maternity patients over non-maternity patients. Instead, a separate add-on payment was established for all births. (See "Maternity Add-On Payment")

- The neonatal intensive care patients are excluded because of their extremely low concentration in the PCCM.

- The basic data source for all calculations is a data base of all Medicaid claims for services provided in fiscal year 1992 (July 1, 1991 through June 30, 1992) which were paid by September 30, 1992. This information has been combined by provider type, aid code, age, sex, and whether the recipient was enrolled in FFS, PCCM, or was a retroactive eligible.

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b. The costs are increased for each provider type based upon a projected percentage of claims which would be expected to be paid more than three months after the fiscal year end. To determine these percentages, the "Provider Claim Payment Analysis" (WL80R09-A) was used for the month of November 1992. The run shows the number of claims paid during the month and how long after the service date they were received by Blue Cross/Blue Shield of Nevada (BC/BSN). Assuming a 30-day processing time, this information was then used to project the percentage of claims by provider type which were paid more than three months after the end of the fiscal year in which services were provided.

c. A base rate is then established by taking the combined average cost per eligible month for the following provider codes:

20	-	Physicians
24	-	Nurse Practitioners
27	-	Radiology
28	-	Pharmacy
43	-	Laboratory
12	-	Hospital Outpatient
17	-	Clinic

- Provider codes 20, 24, 27, 28, and 43 are included at 100% of the ongoing FFS cost because these are the direct services provided by the PCCMs. Provider code 17, Clinic, is included at 55% of total ongoing costs based on previous studies which calculated the percentage of clinic costs related to services covered by PCCMs.

- Provider code 12, Hospital Outpatient (O/P), is included at 63% of the total ongoing FFS average cost. This is based upon an analysis of the costs paid to this provider for which the PCCM provider is at risk.

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d. Additionally, $3.00 is added per eligible month to allow for coverage of administrative and case management costs. This figure is calculated by multiplying the fiscal agent charge per line item processed and the data processing charge per transaction processed by the difference between the PCCM and FFS population average number of items processed.

Maternity Add-On Payments

e. In addition to the normal monthly payment, an additional payment is made to compensate for the costs of maternity care. The rate is determined by comparing the ongoing costs between the FFS maternity and non-maternity groups for females age 18-64. The difference is determined to be the cost attributable to maternity. These costs are then aggregated in the same manner as is used in setting the regular managed care rates, except that the payment is calculated on a statewide basis. A geographical split is not made because of limitations on the data.

f. A total count of maternity hospital stays is also determined. The total FFS inpatient maternity discharges are divided into the ongoing eligible months to determine the average eligible months per mother. This amount is then multiplied by the difference in the cost per month for maternity and non-maternity patients to determine the bonus payment related to the mother.

All rates will be adjusted annually effective January 1 of each subsequent year.

Upper Limit

The total Medicaid payments (medical and administrative payments) to the PCCM contractors cannot exceed the cost of providing the same services on a fee-for-service basis to an actuarily equivalent non-enrolled population group.